Electronic Funds Transfer (EFT)
Authorization Agreement for Automatic Deposits

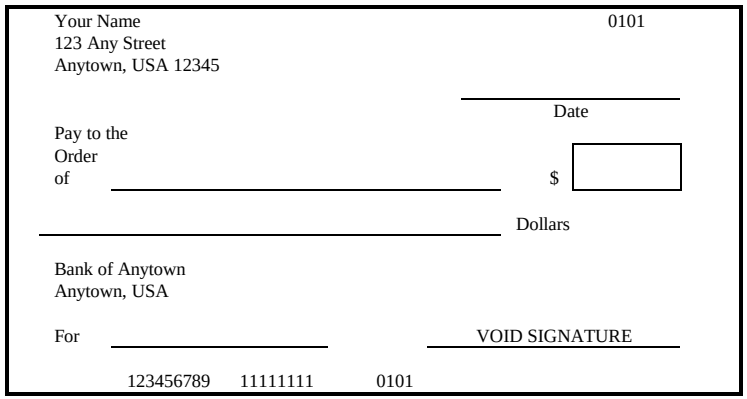
Electronic Data Systems offers Electronic Funds Transfer (EFT) as an alternative to paper check issuance. This service will enable you to receive your Medicaid payments through automatic deposit at your bank while you continue to receive your Remittance and Status Report (RA) at your current mailing address. This process will guarantee payment in a timely manner and prevent your check from being lost through the mail.

To ensure timely and accurate enrollment in the EFT program, please fill out the form on this page, attach a voided check, and return it by mail or fax to:

EDS, 4905 Waters Edge, Raleigh, NC, 27606
Or
Fax: 919-816-3186, Attention: Finance-EFT

EDS will run a trial test between our bank and yours. This test will be done on the first checkwrite you are paid after we receive this form. After that, your payments will go directly to your bank account. Your RA will continue to come through the mail. On the last page of your RA, in the top left corner, it will state "EFT number", rather than "Check number", when the process has begun. Contact EDS Provider Services at 1-800-688-6696 with any questions regarding EFT.

Thank you for your cooperation in making this a smooth transition to EFT, and for helping us to make the Medicaid payment process more efficient for the Medicaid provider community.


Your Name
123 Any Street
Anytown, USA 12345

0101

Date

Pay to the Order of _____ $ _____

_____ Dollars

Bank of Anytown
Anytown, USA

For _____ VOID SIGNATURE

123456789 11111111 0101

We hereby certify this checking or savings account is under our direct control and access; therefore, we authorize Electronic Data Systems to initiate credit entries to our checking or savings account indicated below and the bank name below, hereafter called BANK NAME, to credit the same account number.

BANK NAME_____

BRANCH ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

BANK TRANSIT/ABA NO._____

ACCOUNT NO._____

CHECKING OR SAVINGS _____

This authority is to remain in full force and effect until EDS has received written notification from us of its termination in such time and in such a manner as to afford EDS a reasonable opportunity to act on it.

PROVIDER NAME_____

BILLING PROVIDER NUMBER_____

DATE_____ SIGNED_____

Please list a name and telephone number of someone to contact with questions EDS may have on initiating this automatic deposit.

CONTACT_____ TELEPHONE NUMBER_____

⇦ A VOIDED CHECK MUST BE ATTACHED FOR EACH BANK ACCOUNT IN ORDER FOR US TO PROCESS YOUR EFT.

***ONE EFT REQUEST FORM PER PROVIDER NUMBER**

Revised 2/2004